PRINTED: 05/19/2011 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OM	IB NO. 0938-0391		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
1	OF CORRECTION	IDENTIFICATION NUMBER: 155697	A. BUILDING B. WING	00	COMPLETED 04/29/2011			
	NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN47129				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE		
F0000	State Licensure included the inv IN00088259 Complaint IN00 due to lack of events and the control of the contro	april 25, 26, 27, 28, 29, : 000059 r: 155697 00266560	F0000	Kim Rhoades, DirectorLong Care2 North Meridian StreetIndianapolis, IN 4620 Re: Survey Event ID EJQX Annual and Complaint Survey Dear Kim Rhoades, Please enclosed the plan of correct for Clark Rehabilitation and Skilled Nursing Center's Complaint Survey that took on April 25, 2011 through Ap 2011. Please accept this PC our letter of credible allegati and a request for desk revie or after May 27, 2011. Pleas free to contact me if you have questions concerning the enclosed at (812) 282-8406 Respectfully, Mary Josephi Ann Fenol, HFAClark Rehabilitation & Skilled Nurser Recompleted in the service of the	4 11 ey find ion place oril 29, OC as on ew on e feel //e any . ne			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Donna Groan, RN April 25, 26, 28, 29,

2011

SNF: 09 SNF/NF: 66

Total:

Other:

Total:

Gloria Reisert, MSW

75

10

75

Census payor type: Medicare: 14 Medicaid: 51

Census bed type:

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EJQX11

Facility ID:

000059

TITLE

Center517 North Hallmark

BlvdClarksville, IN 47129

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP - 04/29/2	LETED
	PROVIDER OR SUPPLIER	IL S ND SKILLED NURSING CENTER	STREET A 517 N L	ADDRESS, CITY, STATE, ZIP CO LITTLE LEAGUE BLVD SVILLE, IN47129	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Sample: 15 Supplemental sam	mple: 03				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	ETED
		155697	A. BUIL B. WING			04/29/2	011
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8					
CLADKE	DELIADII ITATIONI AI	ND SKILLED NURSING CENTER			ITTLE LEAGUE BLVD SVILLE, IN47129		
CLARK P	KEHABILHAHON AI	IND SKILLED NORSING CENTER		CLARK	3 VILLE, 11147 129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157	•	nediately inform the					
SS=D		vith the resident's physician;					
		fy the resident's legal					
	· ·	an interested family member					
		accident involving the sults in injury and has the					
		ring physician intervention; a					
		in the resident's physical,					
	•	social status (i.e., a					
	deterioration in he						
	psychosocial statu	us in either life threatening					
	conditions or clinic	cal complications); a need to					
		nificantly (i.e., a need to					
		isting form of treatment due					
		quences, or to commence a					
		nent); or a decision to					
		rge the resident from the					
	facility as specified	u in §483.12(a).					
	The facility must a	also promptly notify the					
	•	own, the resident's legal					
		interested family member					
	· ·	nange in room or roommate					
		ecified in §483.15(e)(2); or					
	a change in reside	ent rights under Federal or					
	State law or regula	ations as specified in					
	paragraph (b)(1)	of this section.					
		ecord and periodically					
		ss and phone number of the presentative or interested					
	family member.	presentative of interested					
	-	review and interview, the	EU	157	The creation and submission of	this	05/27/2011
			1.0	131	plan of correction does not cons		03/4//2011
	-	notify the physician when			an admission by this provider of		
		reviewed for antibiotics in			conclusion set forth in the state		
	a sample of 15 re	esidents did not receive			of deficiencies, or of any violati		
	the full dose of i	intravenous (IV)			regulation.		
	antibiotic (Resid	ent #75) and when 1 of					
	·				This provider respectfully requests that the 2567 plan of correction be		
I	15 residents reviewed for vital sign monitoring in a sample of 15 residents						
	monnoring in a s	sample of 13 lesidents			considered the letter of credible	:	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155697	B. WIN			04/29/2	011
NAME OF	DD OTHDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	C		517 N L	ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER	!	CLARK	SVILLE, IN47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	1	sure reading that fell			allegation and requests a Desk review on or after May 27, 201	1	
	1 1	-set parameters. (Resident			review on of after May 27, 201	1.	
	1 '	ordered ear drops were not					
	provided for 1 o	f 1 resident reviewed with			F 157 Notify of changes		
	an order for ear	drops in a sample of 15.			(Injury/Decline/ Room, Etc.)		
	(Resident #8)				It is the practice of this provide		
					ensure that the attending physic		
					notified of changes in condition		
	Findings include	: :			include medications unable to be given per orders and changes in		
					signs.	vitai	
	1 Review of the	clinical record for			orgins.		
	Resident #75 on 4/28/2011 at 8:50 a.m.,				What corrective action(s) will b	e	
		· · · · · · · · · · · · · · · · · · ·			accomplished for those resident		
		ident had diagnoses			found to have been affected by	the	
	1	but were not limited to,			deficient practice:		
	1	ry of osteomylitis			D 1	. 4	
	-	bone] with MRSA			• Resident #75: MD notifi on4/24/11 and new order for or		
	-	stant staphylococcus			antibiotic obtained.	aı	
	aurous] decubitu	is ulcers, and chronic pain			· The physician for reside	nt	
	syndrome.				#48 was notified on 5/17/11 to		
					blood pressure readings and cur	rent	
	Based on abnorr	nal lab work on			physical assessment. Orders		
	4/10/2011, the p	hysician ordered IV			received.		
	Levaquin 500 m	g [milligrams] QD [every			On 4/26/11, resident #8' physician was notified of Debro		
	day times 7.				solution. New orders were recei		
	,				solution. Ivew orders were recen	iveu.	
	Review of the m	arsing notes included an					
		/2011 at 11:00 p.m. :			How will you identify other res	idents	
	1 *	ted. Pump kept saying			having the potential to be affect		
		In't figure out the			the same deficient practice and	what	
		•			corrective action will be taken:		
	1 -	o run Levaquin. Didn't get			· The facility recognizes t	hat all	
	1	entation was lacking of			residents experiencing a change		
	1 1	ving been notified of the			condition have the potential to l		
	1	d and of being unable to			affected by this practice.		
	administer the fu	ıll dose of ordered			, r		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155697	B. WING		·	04/29/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				LITTLE LEAGUE BLVD	
CLARK F	REHABII ITATION AI	ND SKILLED NURSING CENTER		1	SVILLE, IN47129	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	antibiotic.				Audits of 24-hour report	I
					Medication Administration Rec	ords
					have been completed to review	
	2. Review of the	clinical record for			changes and appropriate physic notifications. No other resident	
		4/25/2011 at 2:55 p.m.,			have been affected.	5
		•			· Licensed nurses were	
		dent had diagnoses			educated on resident change in	
	· ·	but were not limited to,			condition including notifying	
		accident (stroke) with			physician.	
	recurrent trans is	chemic attacks [mini				
	strokes], coronar	y artery disease, status			What measures will be put into	place
	post myocardial	infarct [heart attack], and			or what systemic changes you v	I
	congestive heart	failure.			make to ensure that the deficien	t
					practice does not recur:	
	Review of the nu	rsing notes included the			The Cod 114 2 mod 11 mod 1	
	following entries	_			The facility's policy and procedure was reviewed and no	I
	_				revisions were necessary.	
		15 p [p.m.]: Res in bed			· Licensed nurses were	
		argic but responsive to			in-serviced and will receive	
	touch & speech,				reinforcement education on 5/20	0/11
	85/50Res was o	covered over head [with]			regarding notification of change	es in
	blanket. bp [bloo	d pressure] on			resident condition.	
	readmission was	114/68. MD notified of			· The DNS/designee will	
	results. Just advis	sed to monitor bp for			conduct audits of 24-hour repor	
		gets lower contact MD			Monday through Friday excludi	-
	again. Fam [fami	_			holidays and weekends to identi	·
	again. Fain fiaini	ny] cancu.			changes in condition and approp	priate
	W2/11/2010 0	40 1 70/400			physician notification.	
	- "3/11/2010 - 8:4	40 p: op 78/49"				
					How the corrective action(s) wi	ll be
		was lacking of the			monitored to ensure the deficien	
	physician having	been notified of the			practice will not recur:	
	blood pressure ha	aving dropped lower than				
	the reading at 8:1				· A CQI Audit of Change	in
		•			Condition tool will be utilized	
	On 4/28/2011 at 1:20 p.m., the DoN				weekly x 4 monthly x 2 then	_
		_			quarterly thereafter to monitor f	or
	presented a copy	of the facility's current				l

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN			04/29/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
OL A DIK E		AID OKULLED AUIDOINIO OFAITEE			ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	· · · · · · · · · · · · · · · · · · ·		DATE
	policy on "Reside	•			compliance. MARs will be audited tw	vice	
		ew of this policy at this			weekly x 4 then once weekly x ²		
	•	it was not limited to,			monthy x 2 then quarterly there		
		policy of this facility that			to monitor for compliance.		
	_	sident condition will be			Data collected will be	. C	
		the physician and			submitted to the CQI Committe review and follow up as needed		
	family/responsib	* * .			action plan will be developed as		
	appropriate, time	-			needed for issues identified by t		
		ırs. Procedure:2. Acute			CQI process.		
	_	s: a. Any sudden or					
	_	a resident's condition			Compliance date: May 27, 20:	10	
		marked change in			Comphance date. Way 27, 20.	10.	
		al behavior will be					
		the physician with a					
		cian visit promptly					
	and/or acute care	e evaluation"					
	During an intervi	iew with the Director of					
	Nursing [DoN] o	n 4/28/2011 at 1:30 p.m.,					
ı	she indicated the	physician should have					
	been notified of t	hese issues.					
	During a second	interview with the DoN					
	_	ninistrator on 4/29/2011					
		indicated the nursing					
		serviced on March 8,					
		hysician notification.					
		,					
	3. On 4/25/11 at	12:25 p.m., in					
		esident #8, the resident					
		wax build up in his ears					
		ed treatment for it.					
	On 4/26/11 at 8:1	5 a.m., the clinical					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPI 04/29/2	LETED
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN47129	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	resident's diagnor not limited to desaccident (stroke) Physician Teleph were not limited ear solution - use R (right) ear x 3 with warm water Debrox." Review of the Ap Administration Formedication was the end on 4/26/11. been initialed as In interview with Service on 4/26/11 indicated Pharma 4/22/11 and it has	n the Director of Nursing 11 at 11:55 a.m., she acy sent the Debrox on d not been opened. The t been notified the ear				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	INC	00	COMPL	ETED
		155697	B. WING	INU		04/29/2	011
			1	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK R	PEHARII ITATION AI	ND SKILLED NURSING CENTER			SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0272		onduct initially and					
SS=D		prehensive, accurate,					
	•	oducible assessment of					
	each resident's fur	пспопаг сарасну.					
	Δ facility must mak	ke a comprehensive					
		esident's needs, using the					
		ne State. The assessment					
	must include at lea						
	Identification and	demographic information;					
	Customary routine						
	Cognitive patterns	;					
	Communication;						
	Vision;						
	Mood and behavio						
	Psychosocial well-	ng and structural problems;					
	Continence;	ig and structural problems,					
	•	and health conditions;					
	Dental and nutritio						
	Skin conditions;	,					
	Activity pursuit;						
	Medications;						
	Special treatments						
	Discharge potentia						
		summary information					
		tional assessment					
	protocols; and	the resident assessment					
		participation in assessment.					
		review and interview, the	F02	72	The creation and submission	of	05/27/2011
			102	, _	this plan of correction does n		03/2//2011
	<u>-</u>	assess 2 of 2 residents			constitute an admission by th		
		pheral inserted central			provider of any conclusion se	et	
	· · · · · · · · · · · · · · · · · · ·	venous IV line for			forth in the statement of		
	signs/symptoms	of complications when			deficiencies, or of any violation	on of	
	the line had been	partially/fully dislodged.			regulation. This provider		
	1	nd #48). This deficient			respectfully requests that the		
	`	2 of 15 residents in a			2567 plan of correction be	hle	
	sample of 15 resi				considered the letter of credible allegation and requests a Desk		
	sample of 13 fest	idents.			review on or after May 27, 20		
					10 view off of after may 21, 20	, , , , ,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EJQX11 Facility ID:

000059

If continuation sheet

Page 8 of 23

l 155697		A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/29/2	ETED	
		100007	B. WIN		DDDEGG CIEW CELTE ZID CODE	0 1/20/2	011
NAME OF F	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	₹	1	SVILLE, IN47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	 	TAG			DATE
TAG	Finding includes 1. Review of the Resident #75 on indicated the resiwhich included, paraplegia, historian [infection in the [methicillin resistaurous] decubiture syndrome. Review of the nut and 4/26/2011 in entry: - "4/24/2011 - 3p was in bed getting on the other side Didn't pull out alline in place & company the company the company that is the place with	clinical record for 4/28/2011 at 8:50 a.m., ident had diagnoses but were not limited to, ry of osteomylitis bone] with MRSA stant staphylococcus s ulcers, and chronic pain dicated the following to [p.m.]: Res [resident] ag IV therapy. She turned & pulled picc line out. Il of the way. We taped alled MD [physician]. I Picc Fusion to get		TAG	272 Comprehensive Assessments It is the pract of this provider to ensure residents are comprehensive assessed to include assessment of Peripheral Inserted Central Catheters. What corrective action(s) who be accomplished for those residents found to have be affected by the alleged deficient practice? Residents found to have be affected by the alleged deficient practice? Residents found to have be affected by the alleged deficient practice? Residents found to have be affected by the alleged deficient practice? Residents was notified on 4/24/11 that PICC was pulle New orders received. PICC Fusion evaluated on 4/25/11. The physician for residents was notified on 5/17/11 and order received. Residents completed antibiotic therap with oral medication. How you identify other residents having the potential to be affected by the same allege deficient practice and what corrective action will be taken Residents with peripheral inserted central catheters in the potential to be affected were identified. Appropriately physicians were notified an orders were received to measure PICC lines daily.	ice vely fill en dent d. fil. fil. fil. fil. fil. fil. fil. fil	
	the IV was still is dislodged.	•			Medication Administration Records were updated to include these new orders.		
		clinical record for 4/25/2011 at 2:55 p.m.,			Clinical records were review to ensure PICC length was available. Institutions placi line were contacting for PIC	ng	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLI	ETED
		155697	B. WIN			04/29/20	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	8		1			
01.45145		ND OWN FOR AN IDONE OF STEED			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	indicated the resi	ident had diagnoses			length if not available in		
		but were not limited to,			clinical record. · The care		
	-				plans were reviewed and		
		r accident (stroke) with			updated by IDT. What		
		schemic attacks [mini			measures will be put into p	lace	
	strokes], coronar	ry artery disease, status			or what systemic changes	you	
	post myocardial	infarct [heart attack], and			will make to ensure that the	•	
	congestive heart				alleged deficient practice d	oes	
					not recur · The facility's		
	Di £41				policy and procedure was		
		arsing notes between 3/1			reviewed with no revisions		
	and 4/26/2011 in	dicated the following			needed. · Licensed nurses	; will	
	entry:				be in-serviced on 5/19/2011	and	
	- "3/13/2011 - 9p	p [p.m.]: Res. pulled out			will receive reinforcement		
	picc line to LUE	[left upper extremity].			education on 5/20/11 regard	٠ .	
	•	d [without] pressure being			measurements of PICC line	s	
					daily and if becomes		
	applied. Site nov	v covered			dislodged. How the correct		
					action(s) will be monitored		
	Review of the no	otes failed to locate			ensure the deficient practic	e	
	documentation o	of an assessment of the IV			will not recur? i.e., what		
	site for injury or	complications, the length			quality assurance program	WIII	
		ether the tip of the IV was			be put into place · The	_	
	still intact after i	_			DNS/designee will complete	•	
		t was dislouged.			audits of Medication Administration Records twi	.	
	During an interv	iew with the Director of			weekly for four (4) weeks th weekly for four (4) weeks th		
	Nursing on 4/28/	/2011 at 1:30 p.m., she			monthly for four (4) months		
	indicted there sh	ould have been some type			ensure PICC lines are		
		after the IV had been			measured daily. • The		
	pulled out or disl				DNS/designee will audit		
	panca out of alsi	iougou.			24-hour reports daily for		
					dislodged lines to ensure		
	3.1-31(c)(2)				length of line is measured a	and	
	3.1-31(c)(6)				compared to insertion leng		
	3.1-31(c)(13)				· Data collected will be		
					submitted to the CQI		
					Committee for review and		
					follow up as needed. An ac	tion	
			1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155697 04/29/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE, IN47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE plan will be developed as needed for issues identified by the CQI process. Compliance date: May 27, 2011. F0282 The services provided or arranged by the facility must be provided by qualified persons SS=D in accordance with each resident's written plan of care. The creation and submission of this F0282 A. Based on observation, interview and 05/27/2011 plan of correction does not constitute record review the facility failed to ensure an admission by this provider of any eye drops were administered properly for conclusion set forth in the statement 1 of 1 resident observed receiving eye of deficiencies, or of any violation of drops, during the medication pass, in a regulation. supplemental sample of 3 (Resident #15) This provider respectfully and failed to instill ear drops as ordered requests that the 2567 plan for 1 of 1 resident reviewed for ear drops of correction be considered in a sample of 15 residents. (Resident #8) the letter of credible allegation and requests a B. Based on record review and interview, Desk review on or after May the facility failed to follow a physician's 27, 2011. order for pulse monitoring prior to F 282 Services by qualified administration of the heart medication. persons/per care plan. This deficient practice affected 1 of 2 It is the practice of this provider to residents in a sample of 15 residents ensure that services are provided in accordance with resident's reviewed for vital sign monitoring prior to written plan of care. medication administration in a sample of 15 residents. (Resident #16) What corrective action(s) will be accomplished for those residents found to have been affected by Findings include: the alleged deficient practice? A. 1. On 4/26/11 at 9:25 a.m., LPN #1 The physician for resident was observed preparing medications for #15 was notified on 5/17/11 regarding administration of eye Resident #15. In addition to oral drops. No new orders were medications LPN #1 pulled out Travatan given. Z 0.004% solution to instill 1 drop in both The physician for resident

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155697	B. WIN			04/29/2	011
NAME OF	DDOMINED OD GUIDDI IEI			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF			517 N L	ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER	l .	L	SVILLE, IN47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	#8 was notified on 4/26/11		DATE
	1 '	for glaucoma and			regarding eardrops and new		
	1	olution) 0.15% instill 1			orders were obtained. The		
	drop in both eye	s twice daily for			resident has refused to have		
	glaucoma.				eardrops applied. Family an	d	
		ne room washing hands			physician are aware.		
	""	ves, LPN #1 preceded to			 Licensed nurses were in-serviced on 4/26/11 regard 		
	instill Travatan 1	drop into both eyes.			procedure for administration	-	
	After 1 minute s	he instilled the Alphagan			eye drops.		
	into both eyes.				· The physician of residence	ent	
					#16 was notified on 5/17/11		
	On 4/28/11 at 1:	40 p.m., the Director of			regarding pulse rate prior to administration of heart		
	Nursing Service	(DNS) provided the			medication. No new orders v	were	
	1	edure for "Eye Drop(s).			received.		
	1	ncluded, but was not					
	limited to the fol						
		rops are ordered wait 5			How will you identify other	ul 40	
	1	n each medication. 14if			residents having the potentia be affected by the same alleg		
		eiving two different			deficient practice and what	904	
	1 ~	nurse will wait five			corrective action will be taken	n	
		drops or follow the			The facility recognizes		
	* '	." In interview with the			residents receiving eye/ear d and Digoxin have the potenti		
	1	e, she indicated nursing			be affected.	to	
	was to follow the	e procedure.			· An audit was complete	ed	
					and residents identified.		
	1	1 at 8:15 a.m., the			Medication Administration		
		or Resident #8 was			Records were reviewed to er documentation of	isure	
	reviewed. The r	esident diagnoses			pre-administration pulse rate	s	
	included, but we	ere not limited to			was documented.	-	
	Dementia, Cereb	oral Vascular Accident,			· Licensed nurses were		
	and Diabetes Me	ellitus. Physician			in-serviced on will be inserviced		
	Telephone Order	rs included, but were not			on 5/20/11 on procedure for administration of eye/ear dro		
	limited to "4/22/	11 6 P Debrox ear			and the assessment of hear		
	solution - use as	directed: 2 drops in R			prior to administration of card		
	1	ys - Rinse R ear canal			medications.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155697	B. WIN		<u> </u>	04/29/2	011
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ITTLE LEAGUE BLVD		
CLADK	DELIADII ITATIONI A	ND SKILLED NURSING CENTER		1	SVILLE, IN47129		
		IND SKILLED NORSING CENTER		CLARK	3 VILLE, 11147 129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	with warm water	r after 3rd application of			· The care plans were		
	Debrox."				reviewed and updated by ID	Т.	
	Review of the A	pril 2011 Medication					
	·	Record indicated the			What measures will be put ir	nto.	
					place or what systemic chan		
		to begin on 4/23/11 and			you will make to ensure that		
		The medication had not			alleged deficient practice do		
	been initialed as	being given.			not recur		
	In interview with	n the Director of Nursing			· The facility's policies a		
	Service on 4/26/	11 at 11:55 a.m., she			procedures were reviewed w	vith	
		acy sent the Debrox on			no revision necessary.		
		id not been opened. She			· Licensed nurses will		
		-			receive reinforcement educa	tion	
	_	urses and the medication			on 5/20/11 regarding proper		
	had not been giv	ren.			administrator of eye/ear drop and assessment of heart rate		
					prior to administration of care	-	
					medications.	liac	
					medicatione.		
					How the corrective action(s)	will	
					be monitored to ensure the		
					deficient practice will not rec	ur?	
					i.e., what quality assurance		
					program will be put into place	e	
					· A CQI Audit of MARs	ool	
					will be utilized weekly x 4 mo		
					x 2 then quarterly thereafter	•	
					monitor for compliance of		
					documentation of pulses price	or to	
					administration of Digoxin.		
					· The DNS/Designee w	ill	
					complete random weekly		
					medication pass observation	s for	
					weekly x 4 monthly x 5 then		
					quarterly thereafter to monitor		
					eye and ear drop administra	tion	
					compliance.		

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155697	B. WIN	G		04/29/2	U11
NAME OF P	ROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE		
				1	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		<u> </u>	TAG	DEFICIENCY)		DATE
					Data collected will be submitted to the CQI Commi for review and follow up as needed. An action plan will be developed as needed for issuidentified by the CQI process	oe ues	
					Compliance date: May 27, 2	011	
	B. Review of the	e clinical record for			Joinphanoo dato. May 27, 2		
		4/27/2011 at 8:35 a.m.,					
		dent had diagnoses					
		but were not limited to,					
	severe aortic sten						
		failure secondary to					
	_	sease, chronic atrial					
		rtension, and ischemic					
	cardiomyopathy.	,					
	Review of the Ma	arch and April 2011					
	Medication Adm	inistration Records					
	(MARs) indicate	d the resident had an					
	order for Digoxir	n (a heart medication)					
	0.125 mg - take 1	tablet by mouth once a					
		R [heart rate], [less than]					
	60 dated 10/21/20	010.					
		nad been administered on					
		ys despite the pulse not					
	being taken:						
		3, 3/11, 3/12, 3/13, 3/14,					
	3/15, 3/16, 3/17,	3/22, 3/25					
	- April - 4/8, 4/9, 4/24, 4/25	4/10, 4/19, 4/20, 4/23,					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET COMPLET					
155697		A. BUILDING B. WING 04/29/2011					
	PROVIDER OR SUPPLIER REHABILITATION AI		J. (12.1)	STREET A	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN) REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
F0387 SS=D	4/28/2011 at 11:0 pulse would be d MAR under the r medication being 3.1-35(g)(2) The resident must least once every 3 after admission, ar days thereafter.	ew with LPN #1 on 00 a.m., she indicated the ocumented right on the nurse's initial of the given. be seen by a physician at 0 days for the first 90 days and at least once every 60 considered timely if it					
	the visit was required Based on record in facility failed to expect occurred at least 90 days after admeter 60 days the sampled residents physician visits a supplemental sam 78) This had the	review and interview, the ensure physician visits every 30 days for the first mission and at least once ereafter for 1 of 15 s reviewed for timely and 1 of 1 resident in a mple of 2.(Residents #76, potential to affect 16 identified under the care	F0.	387	The creation and submission of plan of correction does not cons an admission by this provider of conclusion set forth in the stater of deficiencies, or of any violati regulation. This provider respectfull requests that the 2567 p of correction be conside the letter of credible allegation and requests Desk review on or after 27, 2011. F 387 Frequency and timelines physician visits.	titute f any nent on of y blan red May	05/27/2011

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155697	1			04/29/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
	DELLA DULITATIONI A	NID OKU LED NUIDOINO OFNITED			LITTLE LEAGUE BLVD		
CLARK	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤΕ	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					It is the practice of this provide		
	1 The clinical r	record for Resident #76			ensure that each resident is see	-	
		1 4/28/11 at 8:50 a.m. The			physician at least every 30 days		
					the first 90 days after admission	n, and	
	_	oses included, but were			at least once every 60 days		
		ronary artery disease,			thereafter.		
	diabetes mellitus	s and peripheral vascular					
	disease.						
					What corrective action(s) will l		
	 Resident #76 wa	as admitted to the facility			accomplished for those residen found to have been affected by		
		hysician visit was lacking			deficient practice:	tile	
					deficient practice.		
		010, January 2011,			· The physician for reside	ent	
	February 2011 a	nd April 2011.			#76 was contacted for needed v		
					The resident was discharged.	1010.	
	2. The clinical r	record for Resident #78			· The physician for reside	ent	
	was reviewed or	n 4/28/11 at 10:45 a.m.			#78 was contacted for needed v		
	The resident's di	agnoses included, but			The resident was discharged.		
		to Lung Cancer and			· The physician for both		
		•			discharged residents have been		
	Autai Fibrillado	on (rapid heart beat).			updated on the facility practice		
					each resident is to be seen by a		
		as admitted to the facility			physician at least every 30 days		
	on 10/5/10. A P	hysician visit was lacking			the first 90 days after admission	n, and	
	for December 20	010, January 2011, and			at least once every 60 days		
	March 2011.	-			thereafter.		
	In interview on 4/2	8/11 at 12:15 p.m. with the staff			How will you identify other rec	sidonts	
		Medical Records, provided a			How will you identify other res having the potential to be affec		
		sidents under the care of			the same deficient practice and		
		his time, she could not provided			corrective action will be taken:		
	1 *	gress Notes for residents #76			corrective action win be taken.		
		ted there has been a concern			The facility recognizes:	that all	
		being late for visits.			residents have the potential to l		
	• • •	-			affected by this practice.		
	On 4/28/11 at 2:55	p.m., in interview with the			· The Medical Records		
		, she indicated she had spoken			Director completed full facility	audit	
	with Physician #1 r	elated to timely visits.			for timely physician visits. No		
	I		1				1

Facility ID:

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/29/2011
	PROVIDER OR SUPPLIER	II ND SKILLED NURSING CENTER	STREET A	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-22(d)(1) 3.1-22(d)(2)			residents were affected. What measures will be put into or what systemic changes you wake to ensure that the deficier practice does not recur: The Medical Records Director will monitor physician per policy. The Medical Records Director will notify physicians fax prior to date resident is due seen. The physician will be phone (1) week prior to date need be seen by Medical Records/designee. The Medical Records Director will notify the Executi Director will notify the Executi Director if any physicians have delinquent visits. The ED will phone the physician regarding the delinque visit. The facility's medical diwill be notified and will follow with physician as needed and v resident if attending physician I not come in as requested. How the corrective action(s) with monitored to ensure the deficie practice will not recur:	will in visits via to be noned ed to ve nent irector up isit nas
				A CQI Audit of resident physicians visits by the medica records director will be comple weekly x4 then monthly x 5 and	I ted

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,		NSTRUCTION 00	(X3) DATE S COMPL		
		155697	A. BUII B. WIN			04/29/2	011
	PROVIDER OR SUPPLIER REHABILITATION AI	ND SKILLED NURSING CENTER	P	STREET A	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE N. AN OF CONNECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0499		mploy on a full-time,			quarterly thereafter to monitor frompliance. Data collected will be submitted to the CQI Committe review and follow up as needed action plan will be developed as needed for issues identified by the CQI process. Compliance date: May 27, 201	e for . An s	
SS=D	provisions of these Professional staff	essary to carry out the					
	the facility failed Certified Nursing reviewed for curr	review and interview, to ensure 1 of 35 g Assistants [CNAs] rent certifications in a As had maintained a ion (CNA#1)	F0	499	The creation and submission of plan of correction does not cons an admission by this provider of conclusion set forth in the stater of deficiencies, or of any violating regulation. This provider respectfull	stitute f any ment ion of	04/29/2011
	Findings include	:			requests that the 2567 p of correction be conside	olan	
	at 7:30 a.m., indi CNAs. During th certifications, it v certification had Review of the CN (time card) prese on 04/29/11 at 10	e review of the CNAs' was observed CNA #1's expired on 3/17/2011. NA "as-worked" schedule nted by the Administrator 0:35 a.m., indicated CNA een 3/17/2011 and			the letter of credible allegation and requests Desk review on or after 27, 2011. F 499 Employ qualified FT/PT/Consult professional It is the practice of this provice ensure that professional staff must be licensed, certified, or registered in accordance with applicable State Laws.	May s. der to f	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MU	JLTIPLE CO	INSTRUCTION 00	(X3) DATE SUI COMPLET		
ANDILAN	or correction	155697	A. BUILDING				04/29/2011	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD			
		ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE	
1710		gh her certification was	1	1110			DATE	
	not current.	gn ner certification was						
					What corrective action(s) will accomplished for those resid			
					found to have been affected			
	During an intervi	ew with the			the deficient practice:			
	Administrator on	4/29/2011 at 10:35 a.m.,			· C.N.A. #1 completed			
	she indicated CN	A #1 did not have a			re-certification on 4/29/11.			
		ificate and did work after			· C.N.A. #1 became			
	the date her certi	fication expired.			currently active on 4/29/11.			
	3.1-14(s)							
					How will you identify other	1 to		
					residents having the potentia be affected by the same defice			
				practice and what corrective action will be taken:				
					· The facility recognizes	that		
					all residents have the potenti	al to		
					be affected by this practice. The Director of Nursing	,		
					completed an audit of			
					professional staff on 4/29/11			
					current licenses, certifications and registers. All professions			
					staff was current and active in			
					status. No other residents we	ere		
					affected.			
					What measures will be put in			
					place or what systemic chang you will make to ensure that			
					deficient practice does not re			
					•			
					· The DNS/ADNS/desig	nee		
					will complete audits monthly	of		
					licensed, certified and registe			
					professional staff to ensure a and current.	Clive		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE COI A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/29/2011	
NAME OF F	PROVIDER OR SUPPLIER		l l	DDRESS, CITY, STATE, ZIP CODE	UT/28/2011
CLARK F	REHABILITATION AI	ND SKILLED NURSING CENTER	l l	SVILLE, IN47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				 Staff will be notified prexpiration of need for re-certification. Any professional staff without current status will be removed from schedule until active status validated. Findings will be report Continuous Quality Insuranc Committee monthly for reviewand recommendations. 	ed to e
				How the corrective action(s) be monitored to ensure the deficient practice will not rec The DNS/ADNS/desig will conduct 100% audits mo for six (6) months for current active status of professional Data collected will be submitted to the CQI Commi for review and follow up as needed. An action plan will I developed as needed for iss identified by the CQI process Compliance date: April 29, 2	nee nthly staff. ttee pe ues s.
F9999					
	within one (1) me employment, and thereafter, emplo personnel of faci	e of employment, or	F9999	The creation and submission of plan of correction does not cons an admission by this provider o conclusion set forth in the state of deficiencies, or of any violat regulation. This provider respectful requests that the 2567 profits correction be considered.	stitute f any ment ion of

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED			
		155697	B. WING 04/29/2011				
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			517 N L	ITTLE LEAGUE BLVD		
	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		DATE	
		d a documented negative			the letter of credible		
		est result during the			allegation and requests	l l	
		e (12) months, the			Desk review on or after	May	
		in skin testing should			27, 2011.		
	employ the two-s	step method. If the first			F9999 Personnel		
	step is negative,	a second test should be			It is the practice of this provide ensure that all personnel have	1 10	
	performed one (1) to three (3) weeks after			complete health records includi	ng	
	the first step. Th	e frequency of repeat			screening for tuberculosis.		
	testing will deper	nd on the risk of infection			_		
	with tuberculosis						
					What corrective action(s) will b		
	This state rule no	ot met as evidenced by:			accomplished for those resident		
	This state full not filet as evidenced by.				found to have been affected by deficient practice:	the	
	Rased on record	review and interview,			deficient practice.		
		to ensure a complete			· Housekeeping employee	: #1	
		s obtained for 1 of 5			had chest X-Ray completed on		
					4-19-11 showing the ability to		
		eviewed. (Housekeeping			complete duties indicating no a	ctive	
	employee #1)				disease.		
	Findings include	:			How will you identify at a second	idanta	
					How will you identify other res having the potential to be affect		
	Review of emplo	yee files on 04/29/11			the same deficient practice and		
	between 7:30 a.n	n. and 8:30 a.m. the			corrective action will be taken:		
	following was no	oted.					
	_	nployee #1, with start			· The facility recognizes t		
		lacked documentation of			residents have the potential to b	e	
	screening for tub				affected by this practice. The ADNS will complet		
	23.00				audit of all current employees to		
	At 10:30 a.m. on	04/29/11 the			ensure up to date tuberculosis	´	
		ovided a copy of a			screening has been completed.		
	_				_		
		eening" dated 04/29/11,					
	•	al Medicine Physicians.			What measures will be put into		
	_	dicated the following: "			or what systemic changes you v		
	(name of employee) was evaluated in our				make to ensure that the deficien	it	

li ´			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155697	B. WIN	G		04/29/2011	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDER OR SOLVEIER			1	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		ION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE	
		annual TB Screening.			practice does not recur:		
	The Chest X-ray	indicated no active					
	disease. These fi	lms will also be read by			· The facility policy and		
	Radiology Assoc	iates. We will forward a			procedure was reviewed with no)	
	final report when	it is available (usually			revisions necessary.		
	within 5-7 days.)	This employee can			· All employee files will b	e	
	perform his/her d				audited prior to scheduling gene	ral	
	•				orientation by front office, and		
	During interview	with the Executive			department manager. All new hires will be		
	_	9/11 at 12:30 p.m. she			approved by Executive Director	prior	
		st xray was done today.			to general orientation.	prior	
	marcated the ene	st May was done today.			· Department managers ar	e	
	Fauta Cara darra a	1			responsible for obtaining ED		
	Forty-five days e	•			approval to ensure tuberculosis		
		late until the facility			screening completed prior to ge	neral	
		ntation of tuberculosis			facility orientation.	,	
	screening.				· The Assistant Director o	I	
					Nursing will track and complete annual screening for tuberculos	l l	
	3.1-14(t)				aimaar sereening for tabelearos.		
	3.1-14(t)(1)				How the corrective action(s) wi	ll be	
	3.1-14(t)(2)				monitored to ensure the deficien	ıt	
	3.1-14(t)(3)				practice will not recur:		
					· The Business Office will		
					conduct 100% audits of employ		
					files monthly for six (6) months	l l	
					new hires and then quarterly		
					thereafter to ensure screening for	r	
					tuberculosis is in place prior to	start	
					of resident care.		
					Data collected will be	o for	
					submitted to the CQI Committe review and follow up as needed	l l	
					action plan will be developed as	l l	
					needed for issues identified by t		
					CQI process.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		IDENTIFICATION NUMBER: 155697	A. BUILDING	00	COMPI 04/29/2	ETED
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
		ND SKILLED NURSING CENTER		LITTLE LEAGUE BLVD (SVILLE, IN47129		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD: CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
MG	REGUE/HORT OR	ESC IDENTIL TING INFORMATION)	ING	Compliance date: May 2		DATE